***Arizona Medical Board***
***Arizona Regulatory Board of Physician Assistants***

# LICENSE VERIFICATION REQUEST FORM

Please complete and submit this form, along **with payment**, to request a license verification (sometimes called a letter of good standing) be sent to another regulatory board or other organization.

**Licensee Name**: _____ **Licensee Date of Birth** (if known): _____

**License # (if known):**_____

**Requestor's Name** (if different than licensee)**:** _____

**Requestor's Address**:

_____

_____

**Contact Telephone Number for Requestor**: (In case there are questions pertaining to your request)**:** _____

**Type of Arizona License to be Verified:**

- ☐ **M.D.**
- ☐ **M.D. Resident/Post-Graduate Training**
- ☐ **M.D. Pro Bono**
- ☐ **M.D. Locum Tenens**
- ☐ **P.A.**
- ☐ **P.A. Temporary**
- ☐ **Other (specify):**_____

**NOTE: If more than one type of license must be verified, more than one fee must be paid. For example, if both a regular M.D. and a Locum Tenens license must be verified, a fee of 20.00 must be paid ($10.00 for each verification).**

**Name of the Board/Organization to which the Verification is to be sent:** _____

**How would you like the verification to be sent to the Board/Organization (choose one):**

- ☐ **Mailed: Please complete the following:** **Address of Board/Organization:**

  _____

  _____

  _____

  **Attn:**_____

- ☐ **Faxed: Please complete the following:** **Fax # of Board/Organization:** _____

- ☐ **Other:** _____

**NOTE: If delivery via FedEx, UPS, DSL, or a similar company is requested, an envelope and pre-completed waybill, including the requestor's account number for payment, must be provided with this request form.**

**Payment Method:** (There is a $10.00 fee for each verification sent)

- ☐ **Check** (Must be enclosed with this form **-** make checks payable to Arizona Medical Board)
- ☐ **Credit Card** (The credit card payment form accompanying this document must be completed & returned)

**NOTE: If payment does not accompany this form, the verification request will not be processed, and will be returned to the requestor.**

Please mail or fax the written license verification request to:

Arizona Medical Board
Attn: Mary Bober, Public Records Coordinator
9545 E. Doubletree Ranch Rd. Scottsdale, AZ 85258
FAX: (480) 551-2707

**NOTE:** THE ARIZONA MEDICAL BOARD IS NOT RESPONSIBLE FOR VERIFICATIONS THAT HAVE BEEN PROCESSED AND SENT, BUT NOT RECEIVED BY THE INTENDED RECIPIENT. THERE IS A $10.00 FEE FOR VERIFICATIONS WHICH MUST BE RE-SENT. A METHOD OF DELIVERY WHICH PROVIDES TRACKING SERVICE, SUCH AS FEDEX, UPS, DSL, ETC., IS RECOMMENDED TO ENSURE THE RECIPIENT'S RECEIPT OF THE VERIFICATION.

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# PAYMENT CARD AUTHORIZATION

**Payment for:** _____ **MD Lic #** _____
**Physician Name**

## LICENSE VERIFICATION $10.00

**Type of Card:** ☐ **Visa** ☐ **MasterCard**

**Card #:** ☐☐☐☐-☐☐☐☐-☐☐☐☐-☐☐☐☐

**Expiration Date:** ☐☐-☐☐ **(MM-YY)**

**Name as Shown on Payment Card:** _____

**Billing Address of Cardholder:**
(Required)

**Street Address:** _____
**City:** _____ **State:** _____ **Zip:** _____

**Phone Number of Cardholder:** _____
(Required)

**Mailing Address of Cardholder:** (If different from billing address):

**Street Address:** _____
**City:** _____ **State:** _____ **Zip:** _____

**Signature of Cardholder:** _____ **Date:** _____

**Please complete and return this form *with your verification request if paying by payment card.***
**Fax to: 480-551-2707 or**
**Mail to: Arizona Medical Board, 9545 E. Doubletree Ranch Road, Scottsdale, AZ 85258**